



# MONTANA TEACHERS' RETIREMENT SYSTEM

1500 E 6TH AVE  
PO BOX 200139  
HELENA MT 59620-0139  
406 444-3134

TRS Office Use Only

## VERIFICATION OF SUBSTITUTE TEACHING OR TEACHERS' AIDE SERVICE

ALL REQUESTED INFORMATION MUST BE TYPED OR PRINTED LEGIBLY IN DARK INK.

### Part I – To Be Completed By Member:

\_\_\_\_\_  
(Member's Printed Name)

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Mailing Address – Including City, State & Zip+4 Code (If unknown, use 5-digit Zip Code))

\_\_\_\_\_  
(Area Code and Telephone Number)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
(Member's Signature)

\_\_\_\_\_  
(Date)

### Part II – To Be Completed By Certifying Officer:

The information below must be secured from each school district in which the member worked.

Term of Service During Each Fiscal Year (Fiscal Year - July 1 to June 30)				Total Days or Hours Worked	Daily or Hourly Rate of Pay	Gross Salary Earned
From Month	Year	To Month	Year			

**If more space is needed for verification, please attach an additional sheet.**

\_\_\_\_\_  
(Certifying Officer's Printed Name)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
((School District, University, or Institution's Mailing Address – Including City, State & Zip+4 Code (If unknown, use 5-digit Zip Code))

\_\_\_\_\_  
(TRS Six-Digit Employer Number)

\_\_\_\_\_  
(Area Code and Telephone Number)

\_\_\_\_\_  
(Certifying Officer's Signature)

\_\_\_\_\_  
(Date)

**NOTE:** After completing this form, please return it to the Montana Teachers' Retirement System at the above address.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1992,  
ALTERNATIVE ACCESSIBLE FORMATS OF THIS DOCUMENT WILL BE PROVIDED UPON REQUEST